Client ID: _____

Case Management Intake/Assessment

Fields indicated with an asterisk (*) are required to be entered in *PE*. See intake instructions on how/where to enter in *PE*.

_____ _____ _____ _____

***Date** ***Case Manager** ***Location of Assessment** ***Agency assigned Client ID**

If others present:

Name: _____ Relationship to client: _____ Phone: _____

Client Information

***Legal Name:** _____

First Middle Last Preferred

***SSN:** _____/_____/_____ ***DOB:** _____ ***Gender:** ☐ Male ☐ Female ☐ Transgendered

***Current Street Address:** _____ ***Date Moved In**: _____

*** City: _____*County: _____ *State_____ * Zip _____**

***Housing Type**:

☐ 01-Emergency Shelter
☐ 02-Transitional Housing/formerly homeless
☐ 03-Permanent Housing/formerly homeless
☐ 04-Psychiatric Hospital/facility
☐05-SA Tx/Detox facility
☐06-Hospital, non-psychiatric
☐ 07-Jail/Prison/Juv. Detention
☐ 08-Don't Know
☐ 09-Refused
☐10-Room/Apt/House that is Rented
☐ 11-Apt/House/Mobile Home that is Owned
☐ 12-Living in a Family Member's home/apt/room
☐ 13-Living in a Friend's home/apt/room
☐ 14-Hotel/Motel, not paid by emergency voucher
☐ 15-Foster Care/Foster Group Home
☐ 16-Streets/Living in a place not meant for Habitation
☐ 17-Nursing Home
☐ 17-Other:_____

***Rent/Own:** ☐ Rent ☐ Own ☐ Unknown ☐ Does not contribute ***OK to do home visit?** ☐ Yes ☐ No

***Current Housing Programs**: ☐ HOPWA ☐ HUD ☐ Public Housing ☐ Section 8 ☐ TBRA ☐ None

***Mailing address/PO Box: _____**

***OK to send mail?** ☐ Yes ☐ No **Email address: _____ OK to send email?** ☐ Yes ☐ No

***Home Phone: _____ *Message?** ☐ None ☐ Any ☐ Discreet ☐ Name Only

Other (Work/Cell) Phone: _____ Message? ☐ None ☐ Any ☐ Discreet ☐ Name Only

Citizenship: ☐ US ☐ Other (specify):_____

***Race (All identified with):**
☐ White ☐ Black ☐ Asian ☐Native American ☐Native Hawaiian ☐ Alaskan ☐ Pacific Islander ☐ Other
☐ Refused to Report ☐ Unknown

***Ethnicity:** ☐ Hispanic ☐ Non-Hispanic **Veteran:** ☐ Yes ☐ No **If yes, is CL eligible for VA benefits?** ☐ Yes ☐ No

*** Marital Status:** ☐ Divorced ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed ☐ Unknown

***Primary Language:** ☐ English ☐ Spanish ☐ Sign ☐ Other: _____ Will the client need translation services? ☐ Yes ☐ No

***Reading Ability/Literacy:** ☐ No ☐ Yes, ☐ High ☐ Moderate ☐ Limited

Education Level: ☐00- No Schooling ☐01- ≤ 4th grd ☐02- 5th or 6th grd. ☐03- 7th or 8th grd.
☐04- 9th grd. ☐05- 10th grd. ☐06- 11th grd. ☐07- 12th grd., no diploma
☐08- High School Diploma ☐09- GED
☐10- Educational Degree beyond HS diploma (Circle app. level: Associate degree; Graduate degree; Undergraduate degree; post-secondary school; Technical/Trade/Vocational degree)

Client ID: ______________________

*Household Members
Complete in full: All information is required for RW and HOPWA programs

Contact First Name ____________ **Contact Last Name** ____________ **Relationship to Client** ____________

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No
Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: ____________________________
Gender: ☐ Male ☐ Female ☐ Transgendered

Race (All Identified With): ________________________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Monthly Income: ____
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown ☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: ____
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

Contact First Name ____________ **Contact Last Name** ____________ **Relationship to Client** ____________

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No
Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: ____________________________
Gender: ☐ Male ☐ Female ☐ Transgendered

Race (All Identified With): ________________________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Monthly Income: ____
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown ☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: ____
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

Contact First Name ____________ **Contact Last Name** ____________ **Relationship to Client** ____________

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No
Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: ____________________________
Gender: ☐ Male ☐ Female ☐ Transgendered

Race (All Identified With): ________________________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Monthly Income: ____
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown ☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: ____
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

Contact First Name ____________ **Contact Last Name** ____________ **Relationship to Client** ____________

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No
Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: ____________________________
Gender: ☐ Male ☐ Female ☐ Transgendered

Race (All Identified With): ________________________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Monthly Income: ____
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown ☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: ____
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

Client ID: _____

Employment and Transportation

Current Employment Status: ☐ ≥ 35 hrs per week ☐ < 35 hrs per week ☐ Unemployed/Not Disabled ☐Temp Disabled ☐ Perm Disabled ☐ Retired

***Transportation:**

Does client have access to transportation? ☐ Yes ☐ No

If yes, please list primary transportation type: ☐ Bus ☐ Cab ☐ Family Member ☐ Leases Car ☐ Medicaid Van ☐ Owns Car ☐ Other: _____

Finances

****Verification of income is required for all services: HOPWA, RW, & ADAP services**** See ADAP Program Guidelines for acceptable forms of income documentation.

*Source of Income	Received From	$ Client	$ Household/Other
Earned Income/Employment			
Unemployment			
SS-Retirement			
SSI			
SSDI			
Private Disability			
Veteran's Pension			
VA Disability Payment			
TANF/AFDC			
General Assistance (GA)			
Workers Comp			
Former Job Pension			
Child Support			
Alimony or Spousal Support			
Food Stamps			
Other			

Expense Type	Paid To	$ Client	$ Household Other
Rent/Mortgage			
Electricity/Gas			
Water			
Phone			
Cable			
Transportation (Gas, etc.)			
Food			
Child Care			
Car Payment			
Home Owners			
Renter's Insurance			
Property Taxes			
Car Insurance			
Credit Cards/Loans			
Unreimbursed Medical Expenses			
Child Support			
Health Insurance			
Other			

***Total Monthly Income**	
Total Monthly Expenses	
Total Monthly Cash Flow	

***Area for Median Income:** ☐ Charlotte/Gastonia/Concord ☐ Chester Co. ☐ Lancaster Co.

Other Financial Information/Needs:_____

Client ID: _____

Medical Information

HIV STATUS (Self Report)

***Date HIV Diagnosis: _____ *Date of AIDS Diagnosis (if applicable):_____**

***Current Stage of Disease:** ___AIDS ___HIV +, AIDS Status Unknown ___HIV+, Not AIDS ___Indeterminate

***How do you think you got infected? (List all Possible Transmission Routes)**
☐ Blood Transfusion ☐ Exposure to Blood ☐ Hemophilia ☐ Heterosexual Contact ☐IV Drug Use
☐ Man Who has Sex with Men (MSM) ☐ Perinatal ☐ Other ☐ Undetermined ☐ Refused to Report

Primary Care Provider: _____ Infectious Disease Physician: _____

***Primary Care Source:** ☐ Other Public Clinic ☐ Outpatient Clinic (Hospital) ☐ Public Comm. Health Center
☐ RW Title III Clinic ☐ RW Title II Clinic ☐Solo/Group Practice ☐ Unknown ☐ VA or Military Hospital

***Most recent CD4: _____ *Most recent viral load: _____ *Date of lab results: _____**

***How do you rate your overall health?** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

MEDICATIONS/TREATMENT ADHERENCE

*Current Medication Name	*Date Started	*Antiretroviral? (Y/N)	*Condition Treated	Pharmacy used for this med
1.				
2.				
3.				
4.				
5.				
6.				
7.				

***How many antiretroviral meds is the client currently on?** ☐ > 4 ☐ None ☐ 1 ☐ 3 or 4 ☐ 2 ☐ Unknown

***Date antiretroviral therapy was started: _____ *Is CL on HAART?** ☐ Yes ☐ No
* **Is therapy Salvage?** ☐ Yes ☐ No (Salvage therapy will need confirmation from CL's physician)

Any drug allergies? ☐ Yes ☐ No **If yes, please list: _____**

Do you have any side effects or problems taking any of your medications? _____
_____

Have you missed any doses of your medications in the last month? If yes, how many and why? _____
_____

Do you have any cultural or religious beliefs/practices that would prevent you from taking medications or accessing medical care? If yes, Please describe: _____
_____

HIV KNOWLEDGE SCREENING

Why are CD4/viral load tests important to your health? _____

How do you feel about coming to the doctor regularly and why this is important for your health? _____
_____

Describe the client's understanding of HIV? _____
_____

NOTE: Be sure to assess/discuss HIV transmission factors in the risk assessment section to meet the full HIV knowledge screening requirement.

Client ID: _____

MEDICAL ASSESSMENT

Diagnosed health problems other than HIV (Ex: heart disease, diabetes, blood pressure, TB, etc): _____
_____

***Is the client indicated to have a TB test/PPD completed?** ☐ Yes ☐ No, has a Hx of TB ☐ No, has already completed this yr.
If client has a Hx of TB, was a chest x-ray done? ☐ Yes ☐ No If yes, Date of chest x-ray: _____

***Has client already had a TB test this year?** ☐ Yes ☐ No **If yes, please indicate the date and results**:_____

***Currently Pregnant?** ☐ Yes ☐ No ☐ N/A **If yes, expected due date: _____**
Last Pregnancy End Date: _____
Last Pregnancy Outcome: ☐ Elective Abortion ☐ Live Birth ☐ Miscarriage ☐Still Birth

***For female clients: Date and result of last pap smear: _____**
For females over age 40, date of last mammogram: _____

When was the client's last physical completed? _____
***Immunizations:** Last Tetanus shot_____ Last Flu shot _____ Hep B vaccine_____
Pneumovax _____ Other vaccines: _____

History of hospitalizations (When, where, why): _____
_____

HIV-related symptoms experienced: __ Fevers __ Night sweats __ Tiredness __ Weight loss __ Loss of appetite __ Diarrhea __ Thrush __ Short term memory loss __ Yeast infections __ Nausea __ Chills __ Change in vision __ Cold sores ___ None

How do these symptoms and your overall health affect your ability to work and do the things you enjoy?_____
_____

***Opportunistic Conditions: (check all that apply- please indicate if past or current)**

☐ Wasting Syndrome	☐ Bacterial infections	☐ Thrush
☐ Cryptococcal	☐ CMV	☐ Dementia
☐ Hepatitis B	☐ Invasive cervical cancer	☐ Vision loss
☐ Kidney failure	☐ Lymphatic leukemia	☐ Meningitis
☐ Neuropathy	☐ Non-Hodgkin's lymphoma	☐ PCP
☐ Pneumonia	☐ Shingles	☐ Syphilis
☐ Toxoplasmosis	☐ Tuberculosis	☐ Other:_____

VISION/DENTAL/NUTRITION/ADL's/IADL's

When was your last dental check-up? _____ Dental needs now: _____

When was your last eye exam? _____ Vision needs now: _____

How many meals do you eat per day? ____ Is your diet well-balanced/nutritious? ____ Assistance needed with nutrition? ____

Is assistance needed with daily activities (walking, feeding, bathing, grooming, dressing, toileting)? _____
If so, please describe: _____

Is assistance needed with the following activities: housekeeping, shopping, using the phone, medication management, money management)? _____ If so, please describe_____

Risk Assessment

History of sexually transmitted diseases: __ Syphilis __Herpes __Gonorrhea __ Chlamydia __ Genital warts __ None Other:____

***Does the client believe s/he may currently have an STD (Other than HIV)?** ☐ Yes ☐ No **If yes, please specify and refer for treatment if needed or indicate if currently receiving treatment:**
_____

Tell me what you know about how to avoid HIV transmission and/or re-infection?
_____
_____

What types of sex have you <u>ever</u> had? ___ Oral ___Anal ___Vaginal

What types of sex do you <u>currently</u> have? ___ Oral ___Anal ___Vaginal ___ None

Do you currently have sex with? ___ Men ___Women ___Both ____NA

How often do you use condoms for sexual activities? _____
What is the client's understanding of how to use male or female condoms and/or dental dams? _____
_____

If IV drug use was a risk factor, was risk reduction related to clean needles and no sharing needles discussed? ☐ Yes ☐ No

In the past, what has kept you from using condoms/protection? ☐Abusive sex partner ☐Cultural barriers ☐Physical abuse ☐Limited cognitive ability ☐Substance Use/Abuse ☐Limited income to purchase protection ☐Low self esteem ☐Mental health issues ☐Unaware of safe practices ☐Partner unwillingness to practice safer sex ☐Client unwillingness to practice safer sex

Has the client notified past/current sexual partners of HIV status? ☐ Yes ☐ No

If no, describe what steps were taken to assist client in this process (such as referral to DIS):_____
_____

Legal Documents Status

Document	Needed	In Progress	Completed	Not Needed	Not Interested
Will					
Durable Power of Attorney					
Living Will					
Health Care Power of Attorney					
Guardianship					
Burial Plans					

Legal Problems (indicate legal/criminal history):_____

Remark on any pending legal problems or needs: _____

Housing Assessment

Does the client feel that his/her housing is affordable? ☐ Yes ☐ No
Is the client in danger of losing current housing? ☐ Yes ☐ No **If yes, explain: _____**
Are there any structural or functional inadequacies in the client's home? ☐ Yes ☐ No
If yes, please describe: _____
How does the client feel about his/her current housing arrangements? _____
Other comments regarding housing condition/needs:_____
_____

Substance Use

Identify current or past use of any substances including Alcohol, Amphetamines, Steroids, Chew/Snuff, Cigarettes, Club Drugs, Cocaine, Inhalants, IV Drugs, Hallucinogens, Marijuana, Prescription Drugs, Sedatives, OTC Medications, etc.

☐ **No history of substance use**

Substance	Currently Using?	Date of last use?	Average quantity of use (How much)	Frequency of use (How often)	Age of first use?	Does client identify use as a problem to work on?

Has client ever been in treatment? ☐Yes ☐ No **If yes, when and where? _____**

Client ID: _____

Does client feel treatment was effective? ☐Yes ☐ No Comments: _____

If currently using, is the client willing to receive a referral to a substance abuse counselor or program? ☐ Yes ☐ No
If no, explain: _____

Mental Health Assessment

Describe what gives your life meaning / Hobbies you enjoy: _____
_____

Stressors: What are the things that worry you? How long have you worried about them? What have you done in the past to help you deal with the stress? _____
_____

What role does spirituality or religion play in your life? _____
_____

Please list all Mental Health issues or disorders (diagnoses) and treatment (for at least the past 10 years, include types of treatment, length of time in treatment, and provider: _____
_____

Have you ever attempted to hurt or kill yourself or others in the past? ☐Yes ☐ No
If yes, describe when and how? _____ _____

In the last month, have you often experienced feelings of sadness or hopelessness? ☐ Yes ☐ No
In the last month, have you experienced a loss of interest in things you like doing? ☐ Yes ☐ No
Have you recently been bothered by thoughts or feelings that people were trying to hurt you? ☐ Yes ☐ No
Have you recently heard, seen, or felt things that no one else could? ☐ Yes ☐ No

Have you ever been a victim of domestic violence (verbal or physical abuse by a partner/spouse/family member)?
☐Yes ☐ No
If yes, are you currently involved in an abusive relationship? ☐Yes ☐ No Comments: _____

CRISIS INTERVENTION

Are you having thoughts or intentions of hurting yourself? ☐ Yes ☐ No

Are you having thoughts or intentions of hurting others? ☐ Yes ☐ No
If yes, whom? _____

If applicable, do you have a plan to carry out your thoughts? ☐ Yes ☐ No
If yes, what is the plan? _____

If applicable, do you have access to weapons or anything else to hurt yourself or others? ☐ Yes ☐ No
Record specifics of what client has access to (i.e. pills, guns, knives, etc.):_____

If necessary, referral made to: _____**Phone Number**_____
Was an appointment scheduled? ☐ Yes ☐ No **If yes, when:** _____
If no, please comment: _____

MENTAL CONDITION: Document Client's Mental Condition at time of your interview

Behavior ☐Polite ☐Cooperative ☐Suspicious/distrustful ☐Aggressive ☐Hostile ☐Agitated ☐Nervous ☐Withdrawn ☐Uncooperative ☐Resistant

Speech ☐Slow ☐Rapid ☐Pressured ☐Loud ☐Soft ☐Slurred ☐Mumbled ☐Monotone ☐Clear/coherent ☐Confused ☐Stuttering ☐Appropriate Speed and volume

Appearance ☐Neat/ well groomed ☐Unkempt/poor grooming ☐Malodorous (bad smelling) ☐Unusually Dressed ☐Appears older than age ☐appears younger than age ☐not remarkable

Client ID: _____

Movements ☐Steady gait (good balance) ☐Unsteady gait (poor balance) ☐Tics (involuntary twitches) ☐Fidgety/ agitated ☐Smooth movements ☐Appears stiff or uncomfortable when moves ☐Psychomotor retardation (moves slowly)

Level of Consciousness ☐Alert ☐Drowsy ☐Non-responsive

Attention/Concentration ☐Good concentration/attn. ☐Easily distracted ☐Difficulty following interview/answering questions ☐Unable to complete interview because of inattention

Orientation: ☐Oriented to person ☐Oriented to place ☐Oriented to time ☐Non-Oriented ☐Oriented to person, place, & time

Memory ☐Memory intact ☐Recent memory intact ☐Remote memory intact ☐Neither recent nor remote memory intact

Judgment ☐Clear/logical ☐Irrational ☐Cloudy **Thoughts:** ☐Confused/jumbled ☐Clear/logical

Affect (facial expression) ☐Expression fits mood ☐Expression does not fit mood ☐Flat affect (No variety of expression) ☐Blunt affect (less variety of expression than expected) ☐Full range of affect (full variety of expression)

Client's Emergency Contact: _____ **Phone:** _____
Msg. Type: _____ **Aware of CL's HIV Status?** ☐ Yes ☐ No
Be sure to get a release of information for this person

Needs Assessment (should be reflected on action/service plan)

☐Adherence Counseling	☐Housing Assistance	☐Partner Notification	☐ Vision
☐Alcohol/Substance Abuse Treatment	☐ Insurance Premium Asst.	☐Peer Services	
☐ Dental Care	☐Legal Assistance	☐Prescription Assistance	
☐Employment Asst	☐ Medical Care	☐Risk Reduction Education	
☐Emergency Financial Assistance	☐Medical Case Management	☐SSI/SSD	
☐ Financial Counseling	☐Medicaid	☐Support Groups	
☐ Food Bank	☐Medicare	☐Transportation	
☐ Food Stamps	☐Mental Health Counseling	☐Volunteering	

***REFERRALS TO BE MADE:** _____

_____

ALERT MESSAGE IN PROVIDE: _____

SUMMARY

Summarize assessment information in a concise, coherent manner. You are identifying problems and concerns that became evident during your assessment. Please also include strengths, weaknesses that you have identified in the client.

_____
_____
_____
_____
_____
_____
_____
_____

I, _____, certify that all the information I have given is true and accurate to the best of my knowledge and belief. I agree to provide financial and other verification that may be needed to receive services.

Client or Guardian _____ **Date** _____
Case Manager _____ **Date** _____
***Witness (if needed)** _____ **Date** _____
Supervisor _____ **Date** _____

*** If you do not have a third party witness available when signature is indicated by a mark, please write a note of explanation and get your supervisor to initial and date this form.**

Client ID: _____

Benefit Assessment Tool

*PRIVATE INSURANCE

Does this client have Private Insurance coverage for?
Medical Care? ☐ Yes ☐No **Prescriptions?** ☐ Yes ☐ No **HIV Meds**? ☐ Yes ☐ No **Mental Health?** ☐ Yes ☐ No

If for prescriptions only, is this a Medicare Part D Plan? ☐ Yes ☐ No
Company Name: _____ ID#_____ Copy in file? ☐Yes ☐ No

Dental Care? ☐ Yes ☐No
If yes, Company Name: _____ ID#_____ Copy in file? ☐Yes ☐ No

- ***Client may be eligible for one of the SC ADAP Insurance Programs, which will assist the client with either or both the cost of the premium(s) and/or out-of-pocket costs for prescriptions. See "SC AIDS Drug Assistance Program Technical Assistance Guidelines" for eligibility criteria and enrollment procedures.***
- ***Be sure to remind client to notify you in advance if he/she is in danger of losing coverage.***

SSI / SSDI

Does client receive Social Security benefits at this time? ☐ Yes ☐No
Was this client applied for Social Security benefits? ☐ Yes ☐No
If client was applied to Social Security: Date Applied:_____ Date Effective (If Applicable):_____
Date Denied (If Applicable):_____ Reason for Denial:_____

*MEDICAID

Does client currently have Medicaid? ☐ Yes ☐ No **Medicaid ID #** _____ **Copy of card in file?** ☐ Yes ☐ No
If yes,
Is the client on the CLTC Medicaid Waiver program? ☐ Yes ☐ No
Is this a Medicaid Managed Care Organization/Plan? ☐ Yes ☐ No **If yes, which company?** _____
What is the Medicaid Benefit Level? ☐ Comprehensive Coverage ☐ Emergency Svcs. Only ☐ Family Planning Only

- **If no, does client meet Medicaid Program eligibility criteria**? ☐ Yes ☐ No
- **If yes, was client applied to the Medicaid Program?** ☐Yes ☐ No
- **If client was applied to Medicaid, Date Applied**: _____ **Date Effective (If applicable):**_____
  Date Denied (If Applicable): _____

If client was applied to Medicaid, you must obtain and file a copy of the Medicaid application.

If client was not applied to Medicaid, indicate all applicable reasons from the list below:
☐ Does not meet disability criteria/Not disabled
☐ Disabled, but does not meet income criteria ($817/Individual and/or $1100 Couple)
☐ Not Custodial Parent
☐ Disabled, but does not qualify for CLTC-HIV waiver Program
☐ Not a US Citizen
☐ Does not have SSI
☐ Not eligible for Medicaid – ABD (Aged, Blind or Disabled) Program

*MEDICARE

Is client currently enrolled in one or more of the following Medicare Benefit Programs: ☐Yes ☐ No
If yes, **check all that apply:**
☐ Medicare Part A only (no cost to the client and only covers in-patient hospital costs)
☐ Medicare Part B (Medicare program that client pays premium for coverage of medical visits but offers no Rx coverage).
☐ Medicare Part B - SLMB (Medicare program which waives premiums for Medicare Part B and enrolls client, without application, for Part D – Full Low Income Subsidy.)
☐ Medicare – Part D with no subsidy (Medicare program to cover Rxs like a private insurance plan; Client may still be eligible for ADAP services)
☐ Medicare – Part D Low Income Subsidy (Individual income <$13,315 and Couple <$25,035 annually***2008***) **(**Client is not eligible for ADAP services.)

☐ Medicare – Part D – GAPS Program (Medicare program in which client 65 and older with an Individual Income <$19, 14- and Couple <$25,660 receive continuation of coverage during the "Doughnut Hole")

Client ID: _____

***Important: Clients 65 and older who meet the income criteria for Full Low Income Subsidy should apply to FLIS before applying to GAPS Program**.

Does client meet Medicare Program eligibility criteria? ☐ Yes ☐No

- **If no, is the client disabled but hasn't met the 2 year wait time for Medicare eligibility?** ☐ Yes ☐No
- **If yes, when will client be eligible to sign up for Medicare benefits? _____**

***PAYMENT SOURCE (PLEASE LIST ALL THAT APPLY)**

☐ Private Insurance ☐ Other Public: Medicare, VA ☐ Medicaid ☐ Uninsured

***SC AIDS DRUG ASSISTANCE PROGRAM (ADAP)**

(ADAP includes: ADAP Direct Dispensing, ADAP Insurance Co-payment Program, and ADAP Health Insurance Continuation)

Is client currently on ADAP? ☐ Yes ☐No **If yes, which program(s):_____**

If "No" has client ever been on ADAP? ☐ Yes ☐No
If yes, was the client terminated due to noncompliance? ☐ Yes ☐No

OTHER PRESCRIPTION ASSISTANCE PROGRAMS

Does client need additional assistance for prescriptions while waiting for a pending application to one of the above mentioned prescription coverage or benefit programs? ☐ Yes ☐No

Is the client ineligible for prescription coverage benefits? ☐ Yes ☐No

OTHER BENEFITS

Is the client currently receiving food stamp benefits? ☐ Yes (active) ☐ Not eligible ☐ Applied ☐ Not interested/needed

Is the client receiving WIC benefits? ☐ Yes (active) ☐ Not eligible ☐ Applied ☐ Not interested/needed

Does the client need assistance applying for other compassionate care/indigent care programs related to medical needs?
☐Yes ☐No **If yes, explain:** _____
_____

Date: _____ Name of Individual Completing Form: _____

Signature of Individual Completing Form: _____